"The Bridge to Peace of Mind"
HOSPICE
NETWORK OF MARYLAND

June 10, 2005

The Honorable Robert E. Nicolay
Chairman
Certificate of Need Task Force
Maryland Health Care Commission
4160 Patterson Ave.
Baltimore, MD 21215

Dear Commissioner Nicolay:

The Hospice Network of Maryland, representing all 30 hospices in the State of Maryland, appreciates the opportunity to provide its views on the Certificate of Need (CON) process for hospice care to the Health Care Commission's Certificate of Need Task Force. **The Hospice Network urges the Task Force to recommend that the Commission take no action to alter the current CON process for Hospice**. The current system has been reviewed and approved by the Health Care Commission and State Legislature as recently as 2001 and 2003, respectively. As the staff and legislature found, the CON for hospice in Maryland has produced great benefits for the development of Hospice care in the State. Indeed, altering the current CON process for hospice could have serious adverse consequences for the quality and availability of Hospice care in the State.

The Hospice Network encourages the Task Force to review Heath Care Commission's report to the legislature on CON dated January 1, 2001.[1] In that report, "[t]he Commission recommend[ed] that the General Assembly maintain existing Certificate of Need regulation for new or expanded hospice services."[2] The Commission concluded that

> Among the majority of hospice providers as well as the statewide professional association, a strong consensus exists that it would be preferable to continue oversight of market entry through the CON program. Analysis of utilization data indicates that available hospice services are meeting the needs for end-of-life care in Maryland. Retaining the authority to consider new hospice providers only when additional need warrants will help maintain the stability of this mission-driven, largely non-profit provider network that is heavily dependent on volunteers and community donations. Approval of this recommendation would not preclude the Commission from working with the Department's Office of Health Care Quality to strengthen State licensure requirements for hospice care.[3]

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[1] *See* An Analysis and Evaluation of Certificate of Need Regulation in Maryland, Phase I, Final Report to the Maryland General Assembly, Maryland Health Care Commission, January 1, 2001. A copy of the relevant portions of the report is attached for the Task Force's reference.

[2] *Ibid.*, p. 151.

[3] *Ibid.*

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The CON process for hospice was also recently affirmed by the legislature in the overwhelming passage of SB732 during the 2003 legislative session. That legislation re-stated the General Assembly's intent that a Certificate of Need is required to establish or transfer a hospice program in this State.[4]

Hospice care in Maryland has flourished under the existing regulatory structure. Hospice care in Maryland is a vibrant and far-reaching service, enjoying a stability that serves to enhance the availability and quality of care Marylanders enjoy at end-of-life. Most jurisdictions in the State are served by multiple Hospice programs. Even in very remote and rural regions of the State, at least one community-based Hospice program, and sometimes more, serves citizens in those areas. Overall, Hospice utilization in the State compares favorably with national averages. Moreover, Maryland serves the third highest percentage of African Americans (after South Carolina and Georgia) of all states reporting data as part of the National Hospice and Palliative Care Association's National Data Set..

More importantly, the CON process has protected the citizens of the State of Maryland from some of the worst excesses of unscrupulous Hospice providers that were unmasked during Operation Restore Trust, the initiative launched by the Office of the Inspector General of the U.S. Department of Health and Human Services in 1997 to root out fraud in the provision of Hospice care. A study of the state of hospice regulation across the nation conducted as part of the Commission staff's 2000 report concluded:

> It may be more than coincidental that the worst of the excesses uncovered by Operation Restore Trust were concentrated in states without CON regulations and the subsequent reduction in capacity and use was less pronounced in states with CON regulation. On the whole, there appears to have been greater stability in states with regulation.[5]

Modifications to the CON process for hospice carry the risk of de-stabilizing this carefully developed and highly effective service network. Moreover, the prospect any change the current regulatory structure could not come at a more unpropitious time for many Maryland Hospices.

Hospices in Maryland are facing many challenges including the manner in which Hospice care is reimbursed by Medicare, Medicaid and private insurance companies, the skyrocketing costs of medications and other medical services, declining lengths of stay, and the availability of qualified and committed Hospice staff and volunteers. Adding to this volatile mix the prospect of regulatory change, especially where no evidence suggests that such change would improve the

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[4] See SB742, codified at MD Code Health-Gen., art. 19 § 120.

[5] Certificate of Need Regulation of Home Health and Hospice Services in the United States, Maryland Health Care Commission, Sept. 15, 2000 at 29 (*emphasis added*). A copy of this document is attached for the Task Force's reference.

nature or quality of Hospice care, would adversely impact the Hospice care provided to the residents of this State.

Nearly 80% of Hospice services in Maryland are reimbursed by Medicare. (MHCC 2003 data.) The Medicare Hospice Benefit is structured as all-inclusive, predetermined, daily payments for four levels of service. This risk-bearing payment system, based on a daily capitated rate, is coupled with a requirement that the Hospice meet all of the patient's medical, psychosocial, spiritual, and personal needs related to the terminal illness. These predetermined daily payments have not increased relative to dramatic growth in the cost of palliative care treatments, the much-discussed explosion in the cost of prescription medicine, or the need to compete in a tight labor market with the higher salaries demanded by a shrinking skilled medical labor pool.

Hospices in Maryland also are caring for patients for periods that are too short for optimal care or financial stability. Medicare's capitated payment system assumes a bell curve with a significant majority of days in care at medium-cost levels. In this way, high initial costs are amortized over longer payment periods. This is not the situation today. As is the case across the country, in 2003, the median length of stay for all Hospice patients in Maryland was slightly more than three weeks. (MHCC 2003 data.) The most expensive Hospice days, which have always been the first several and the last several, are now nearly half of all days. Care for patients so close to death is extremely costly. These patients and their families require intensive services from the Hospice team, and expensive medications, equipment and palliative measures. The effect is significant economic pressures for Hospices committed to providing the highest quality of care to patients.

Those who care for Hospice patients are unique. Because death and dying are not easy subjects for most Americans, most who enter the medical or social work fields do not think of Hospice work as their career of choice. Those who would choose Hospice, therefore, represent a small percentage of a shrinking medical labor pool. The overall shortage of registered nurses in Maryland, and declining enrollments in social work programs, plus the nature of Hospice work itself, has led to a job market that is very competitive. This translates directly into increased costs, as Hospices must offer a premium to attract qualified and committed Hospice staff.

The fact that death is not an easy subject for our culture is also reflected in the number of people in a community who are available to serve as Hospice volunteers. Many organizations compete for the time and attention of committed volunteers. For Hospice, volunteers are essential members of the caregiving team. Both the grass roots origins of most non-profit Hospice programs and Medicare's requirement that certified hospices train and use volunteers mean that it is essential that hospices successfully attract volunteers. But the pressure is increasing to recruit the special kind of volunteer needed in the Hospice program.

Today, the vast majority of Hospices in the State of Maryland are non-profit agencies. Most of these institutions grew out of community efforts to improve care of the dying for local residents. Because of increasing cost pressures, these hospices have come to rely upon the generosity of local donors for fundraising dollars. In some cases, charitable donations cover over 25% of a community hospice program's operational costs. According to MHCC data for 2003,

only six hospices in the State can break even without significant fundraising efforts. But Hospices are not alone in needing the additional economic support provided by philanthropic resources. These days, competition for community donations has become intense as more and more non-profit organizations are turning to the private sector for financial help.

Introducing increased economic "competition" in the provision of Hospice services in Maryland by modifying or eliminating the Certificate of Need will mean the following: In addition to coping with the economic pressures imposed by a capitated reimbursement system and shorter lengths of stay, competing with other health care institutions for skilled staff, and with other charitable enterprises for fundraising dollars and volunteers, hospices will have to divert resources from providing care to the dying to compete with one another. This additional economic burden could have serious consequences for quality Hospice care.

Increased competition will mean that Hospices that have developed under Maryland's existing regulatory structure could be faced with a number of adverse scenarios. Aggressive competitors who may be more concerned with cutting costs, while sacrificing quality of care, to achieve short term financial gain will be able to enter selected markets. Such competitors could divert patients from existing providers and threaten their stability. Existing hospices will be compelled to utilize scarce dollars not for patient care but to compete against these outside companies which may be subsidized by other corporate divisions.

Since there is little or no market incentive for hospice providers to offer services in remote and sparsely populated parts of the state (most providers serving those areas survive only by virtue of strong community and financial support), any growth in hospice services is most likely to take place in communities where there is already intense competition. This will further dilute the resources available to the existing programs and could adversely impact their ability to provide high quality service.

Existing Hospice care in the State of Maryland works very well to meet the end-of-life needs of the citizens of this State. It is not perfect, however. The Hospice Network of Maryland is committed to working with its members to expand and improve care to terminally ill patients in nursing homes, to terminally ill children, and to other populations who may be identified as requiring additional or expanded hospice services. These initiatives will be supported under the existing regulatory structure. Changes in the CON would distract providers' from meeting these needs to focus on competition rather than care.

In summary, the Hospice Network of Maryland appreciates the efforts of the Task Force to review the role of CON across the range of health care services in the State. What is clear is that the current regulatory structure has enabled a stable, vibrant community of Hospice providers to attend well to the needs of the terminally ill citizens of the State. The staff's work in 2000 and 2001 provide strong evidence for retaining current regulations. Nothing has occurred in the intervening four years to suggest that the regulatory structure should be changed or to blunt the adverse consequences of such a change. Because it is so acutely cognizant of these consequences and their potential effect of the availability and quality of Hospice care available to

the citizens of this State, the Hospice Network of Maryland urges the Task Force to recommend that the Commission retain the existing CON regulation for hospice care.

Sincerely,

Erwin E Abrams

Erwin E. Abrams
President

Enclosures

1. Selected portions of An Analysis and Evaluation of Certificate of Need Regulation in Maryland, Phase I, Final Report to the Maryland General Assembly, Maryland Health Care Commission, January 1, 2001
2. Certificate of Need Regulation of Home Health and Hospice Services in the United States, Maryland Health Care Commission, September 15, 2000.

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June 10, 2005

The Honorable Robert E. Nicolay
Chairman
Certificate of Need Task Force
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Nicolay,

I am pleased to supplement my public comment and written comments with the enclosed Supplemental Comments of the Hospice Network of Maryland. The Network stands ready to provide additional assistance to the Task Force in any way possible.

Sincerely,

Erwin E Abrams

Erwin E. Abrams
President

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Maryland Health Care Commission
Certificate of Need Task Force

Supplemental Comments
of the
Hospice Network of Maryland
June 10, 2005

The Hospice Network of Maryland (HNM) appreciates the opportunity to supplement its public statement by HNM President Erwin Abrams and its written comments submitted to the Task Force at the June 7, 2005 Public Forum conducted by the Certificate of Need (CON) Task Force. These supplemental comments are intended to address issues raised by certain testimony delivered at the Public Forum regarding the economic impact of CON on the provision of health care services generally and on the provision of hospice services specifically.

The implication of certain representations expressed at the Public Forum was that without CON, economic efficiencies of competition would reduce hospice costs and improve hospice quality and that this has occurred in states that either have repealed CON for hospice or never imposed it in the first place. **The suggestion of those who support elimination of the CON that the residents of this State would receive better hospice care at lower costs could not be more misguided.**

Hospice operations data collected by the Maryland Health Care Commission support the Network's contention that eliminating the CON would undermine the thriving, grass-roots network of hospice providers in this State. Moreover, a limited data set compiled by the National Hospice and Palliative Care Organization (NHPCO) demonstrate that hospices in states without CON fail to enjoy the cost efficiencies touted by those who would eliminate CON in Maryland to achieve that purpose. **Most important, the data are clear that hospice care in CON states exceeds hospice care in non-CON states in terms of the quality and effectiveness of patient care and family support.**

Hospice care is unique among health care services both in the range of services provided not only to the patient but also to the family and in the manner in which it is reimbursed by Medicare, which represented nearly 80% of hospice reimbursement in the State of Maryland in 2003. (MHCC data). Participation in Medicare requires, among other things, that hospices provide a comprehensive set of core services to each patient and family including a team that is comprised of a registered nurse, social worker, home health aide, pastoral counselor, and volunteers. Hospices are also required to supply whatever durable medical equipment the patient may need to be cared for at home. This equipment may include a hospital bed, wheel chair and bedside commode, among other items. In addition, hospices must supply oxygen where needed and all the medications and therapies necessary to alleviate pain and other symptoms related to the patient's terminal diagnosis.[1]

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[1] *See* 42 CFR §418. The Center for Medicare and Medicaid Services has recently published proposed revisions to the Medicare Hospice Conditions of Participation (CoP), 70 *Fed. Reg.* 30840 that would, among other things, increase the administrative and compliance requirements for hospice participation.

The Medicare hospice reimbursement for all of these services is administered on a *per diem* basis. The reimbursement rates for routine home care for the current fiscal year for hospices in the State of Maryland range from $117.57 to $137.26.[2] These rates represent an average increase of 8.06% over the rates for FY 2004, despite double digit rises in the cost of prescription drugs, hospices' single largest direct cost item.

The most accurate comparison of cost to reimbursement can be made with 2003 Maryland hospice data collected by the Maryland Health Care Commission relative to the average Medicare reimbursement rate for FY2003. The average total cost per day for hospice care in 2003 in this State was $153. The average Medicare reimbursement for Maryland hospices in 2003 was $116.07. Without charitable dollars, hospices in Maryland would certainly fail.[3] Indeed, fundraising dollars accounted for an average of 17% of total hospice revenue in 2003. In addition, according to the MHCC 2003 report, Hospice Network volunteers provided 233,844 hours of service. Valued at $10 per hour, these hospices' would have had $2,338,440 in additional manpower/staff costs. The volunteers make a vital difference in the provision of hospice services.

National data from 2003, although limited, show that hospices in states without CON do little better in controlling costs.[4] In a sample of hospices from 13 states, 4 with CON and 9 without, the average statewide cost per patient day ranged from $93 to $190. The difference in the average costs per day in states with CON (including Maryland) and states without CON was 2%, $142 compared to $139. The absence of CON regulation clearly has little bearing on controlling hospice costs.

With little difference in cost control, largely attributable to both the fixed requirements for hospice care expenditures and the fixed reimbursement level regardless of regulatory status, the data also fail to demonstrate that competition in non-CON states produces higher quality patient care. In hospice terms, quality is measured both quantitatively by, for example, speed and effectiveness of pain and symptom control, and qualitatively by the subjective perception of family members of the warmth, care and compassion shown by the visiting hospice staff. Absent state-level outcome data on these measures, two items from the National Data Set may be viewed as effective indicators of quality of care: total staff visits per admission and total expenditures per admission. Total staff visits per admission represents the attention and focus devoted to each patient and family. On this score, hospices in CON states far exceed hospices in non-CON states by significant margins. The average number of visits per admission for hospices in non-CON states is 35.8, in CON states **40.7**. With the average length of stay for all hospice patients, regardless of regulatory status, at 55 days this 14% difference means that hospice patients in CON states are receiving significantly more hospice staff attention and care than hospice patients in non-CON states.

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[2] This is the rate for Routine Home Care, which represented 80% of patient care days in this State in 2003.

[3] In 2003, 87% of hospices in Maryland were not-for profit.

[4] Although all Medicare certificated hospices are required to file an annual Cost Report with CMS, these data have not been aggregated either nationally or by State and are not publicly available. Similar data is submitted voluntarily to NHPCO for the National Data Set. *See,* National Hospice and Palliative Care Organization, 2003 National Data Set Summary Report, Perforum, Hanover, NH.

A similar difference is seen in the average hospice expenditure per admission. Given the cost of staff time, equipment and, especially, palliative medications and therapies, the more a hospice spends on these items, the more likely it is that the patient's comfort and symptom control needs are being addressed effectively. The NHPCO data show that hospices in CON states spend 10% more on average per admission than hospices in non-CON states, $7,696 compared to $7013 per admission. More specifically, hospices in CON states spend $982 per admission on drugs, biologicals and infusion therapies compared to $779 per admission spent by hospices in non-CON states.

The data demonstrate that CON creates an environment within which patient care, not cost efficiency, is the controlling value in attending to the terminally ill. Unregulated competition in hospice services does not improve patient care, but rather very significantly the reverse. The Hospice Network of Maryland therefore re-iterates its strong support for retaining the Certificate of Need for hospice in Maryland and urges the Task Force to recommend that the Maryland Health Care Commission make no changes to the CON for hospice.